



Comprehensive Pain Institute

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**Medical Records
Release**

To: _____

You are hereby authorized to release to:

James Lin, M.D.
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Thousand Oaks, CA 91360
Tel: 805-557-7050
Fax: 805-557-4992

Information contained in your medical
records in regard to my case,
specifically including those marked below:

- | | |
|---|---|
| <input type="checkbox"/> MRI | <input type="checkbox"/> Lab results |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Other |
| <input type="checkbox"/> History and Physical | _____+ |
| | _____ |
| | _____ |

Patients Signatures: _____

Patients Name: _____

Patients DOB: _____

Date: _____

Witness: _____

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